

		FOR OHF USE					

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0039503</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>ODIN HEALTHCARE CENTER</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/00</u> to <u>12/31/00</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>300 N. GREEN STREET</u> <u>ODIN</u> <u>62870</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>MARION</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) <u>Linda Holtzscheiter</u> (Title) <u>Reimbursement Manager</u>	
Telephone Number: <u>(618) 775-6404</u> Fax # <u>(618) 775-6404</u>		Paid Preparer (Signed) _____ (Date) _____ (Print Name and Title) <u>Cathy Simeoni, Manager - Healthcare Consulting</u> (Firm Name & Address) <u>Kellogg & Andelson, Accountancy Corporation</u> <u>16162 Beach Blvd, #308, Huntington Beach, CA 92647</u> (Telephone) <u>(714) 596-7713, fax 596-7721</u> Fax # ()	
IDPA ID Number: <u>351921817003</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
Date of Initial License for Current Owners: <u>06/07/94</u>			
Type of Ownership:			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____		<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	
<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____			
In the event there are further questions about this report, please contact: Name: <u>Cathy Simeoni</u> Telephone Number: <u>(714) 596-7713, Ext 12</u>			

STATE OF ILLINOIS

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Facility Name & ID Number ODIN HEALTHCARE CENTER# 0039503 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>33</u>	Skilled (SNF)	<u>33</u>	<u>12,078</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>66</u>	Intermediate (ICF)	<u>66</u>	<u>24,156</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>99</u>	TOTALS	<u>99</u>	<u>36,234</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>2,931</u>	<u>512</u>	<u>2,909</u>	<u>6,352</u>	8
9	SNF/PED					9
10	ICF	<u>17,770</u>	<u>3,183</u>		<u>20,953</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>20,701</u>	<u>3,695</u>	<u>2,909</u>	<u>27,305</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 75.36%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)NONEF. Does the facility maintain a daily midnight census? YESG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☒ NO ☐

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 06/07/94

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 06/07/94 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter numberof beds certified 14 and days of care provided 2,900Medicare Intermediary AdminaStar, Illinois

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31 Fiscal Year: 12/31

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

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Facility Name & ID Number

ODIN HEALTHCARE CENTER

0039503

Report Period Beginning:

01/01/00

Ending:

12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	132,513	8,030	8,164	148,707		148,707		148,707		1
2	Food Purchase		107,192		107,192		107,192	(10,928)	96,264		2
3	Housekeeping	84,372	8,498		92,870		92,870		92,870		3
4	Laundry	28,373	11,516		39,889		39,889		39,889		4
5	Heat and Other Utilities			88,273	88,273		88,273		88,273		5
6	Maintenance	19,537	18,647	22,859	61,043		61,043	317	61,360		6
7	Other (specify):*										7
8	TOTAL General Services	264,795	153,883	119,296	537,974		537,974	(10,611)	527,363		8
	B. Health Care and Programs										
9	Medical Director			5,912	5,912		5,912		5,912		9
10	Nursing and Medical Records	748,716	57,890	12,373	818,979		818,979		818,979		10
10a	Therapy	153,228	292	2,966	156,486		156,486	(5,903)	150,583		10a
11	Activities	33,101	4,474	1,529	39,104		39,104		39,104		11
12	Social Services	24,954		1,838	26,792		26,792		26,792		12
13	Nurse Aide Training										13
14	Program Transportation			5,562	5,562		5,562		5,562		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	959,999	62,656	30,180	1,052,835		1,052,835	(5,903)	1,046,932		16
	C. General Administration										
17	Administrative	57,365			57,365		57,365		57,365		17
18	Directors Fees										18
19	Professional Services			1,895	1,895		1,895	11,130	13,025		19
20	Dues, Fees, Subscriptions & Promotions			5,968	5,968		5,968	208	6,176		20
21	Clerical & General Office Expenses	76,019	11,665	89,662	177,346		177,346	9,312	186,658		21
22	Employee Benefits & Payroll Taxes			237,628	237,628		237,628		237,628		22
23	Inservice Training & Education			425	425		425		425		23
24	Travel and Seminar			7,947	7,947		7,947	1,881	9,828		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			54,053	54,053		54,053	1,198	55,251		26
27	Other (specify):*										27
28	TOTAL General Administration	133,384	11,665	397,578	542,627		542,627	23,729	566,356		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,358,178	228,204	547,054	2,133,436		2,133,436	7,215	2,140,651		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

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Facility Name & ID Number **ODIN HEALTHCARE CENTER** #0039503 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			(9,394)	(9,394)		(9,394)	171,437	162,043			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			756	756		756	29,670	30,426			32
33	Real Estate Taxes			40,004	40,004		40,004		40,004			33
34	Rent-Facility & Grounds							42,618	42,618			34
35	Rent-Equipment & Vehicles			8,648	8,648		8,648		8,648			35
36	Other (specify):*											36
37	TOTAL Ownership			40,014	40,014		40,014	243,725	283,739			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		76,009	14,077	90,086		90,086		90,086			39
40	Barber and Beauty Shops			9,206	9,206		9,206	(9,206)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,352	54,352		54,352		54,352			42
43	Other (specify):*			5,977	5,977		5,977	49,283	55,260			43
44	TOTAL Special Cost Centers		76,009	83,612	159,621		159,621	40,077	199,698			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,358,178	304,213	670,680	2,333,071		2,333,071	291,017	2,624,088			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number ODIN HEALTHCARE CENTER

0039503

Report Period Beginning: 01/01/00

Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(10,928)	2		4
5	Telephone, TV & Radio in Resident Rooms	(29)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(5,265)	21		18
19	Entertainment				19
20	Contributions	(105)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(31,546)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	140,559			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 92,686		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	198,331		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 198,331		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 291,017		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	\$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES			Sch. V Line
	Amount	Reference	
1			1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
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79			79
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83			83
84			84
85			85
86			86
87			87
88			88
89			89
90			90
Total	140,559		

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ODIN HEALTHCARE CENTER

0039503

Report Period Beginning:

01/01/00

Ending:

12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(10,928)	0	0	0	0	0	0	0	0	0	0	(10,928)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	317	0	0	0	0	0	0	0	0	0	317	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(10,928)	317	0	0	0	0	0	0	0	0	0	(10,611)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	(5,903)	0	0	0	0	0	0	0	0	0	0	(5,903)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(5,903)	0	0	0	0	0	0	0	0	0	0	(5,903)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	11,130	0	0	0	0	0	0	0	0	0	11,130	19
20	Fees, Subscriptions & Promotions	0	208	0	0	0	0	0	0	0	0	0	208	20
21	Clerical & General Office Expenses	(52,714)	62,026	0	0	0	0	0	0	0	0	0	9,312	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	1,881	0	0	0	0	0	0	0	0	0	1,881	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	1,198	0	0	0	0	0	0	0	0	0	1,198	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(52,714)	76,443	0	0	0	0	0	0	0	0	0	23,729	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(69,545)	76,760	0	0	0	0	0	0	0	0	0	7,215	29

Summary B

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

Facility Name & ID Number ODIN HEALTHCARE CENTER

0039503

Report Period Beginning:

01/01/00

Ending:

12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mariner Post Acute Network	100	See Attached Pg 6.1		Mariner Post Acute Network	Atlanta, GA	Bookkeeping & Management

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V	5	Utilities	\$	Mariner Post Acute Network	100.00%	\$ 0	\$	1
2	V	6	Repairs and Maintenance		Mariner Post Acute Network	100.00%	317		2
3	V	19	Professional Services		Mariner Post Acute Network	100.00%	11,130		3
4	V	20	Fees, Subscriptions, Promotions		Mariner Post Acute Network	100.00%	208		4
5	V	21	Clerical and General Office Exp		Mariner Post Acute Network	100.00%	62,026		5
6	V	24	Travel and Seminar		Mariner Post Acute Network	100.00%	1,881		6
7	V	26	Insurance Premium		Mariner Post Acute Network	100.00%	1,198		7
8	V	32	Interest Expense		Mariner Post Acute Network	100.00%	29,670		8
9	V	34	Rental & Leasing		Mariner Post Acute Network	100.00%	42,618		9
10	V	43	Other Expenses		Mariner Post Acute Network	100.00%	49,283		10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$ 198,331	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number **ODIN HEALTHCARE CENTER** # **0039503** Report Period Beginning: **01/01/00** Ending: **12/31/00**

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number ODIN HEALTHCARE CENTER# 0039503

Report Period Beginning:

01/01/00Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Mariner Post Acute NetworkStreet Address One Ravine Dr., Suite 1500City / State / Zip Code Atlanta, GA 30346Phone Number (770) 379-8203Fax Number (770) 399-1971

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Facility Costs			\$ 212,153	\$		\$ 0	1
2	6	Repairs and Maintenance	Facility Costs			1,115,193			317	2
3	19	Professional Services	Facility Costs			19,156,199			11,130	3
4	20	Fees, Subscriptions, Promotions	Facility Costs			352,775			208	4
5	21	Clerical and General Office Exp	Facility Costs			51,126,150			62,026	5
6	24	Travel and Seminar	Facility Costs			5,661,045			1,881	6
7	26	Insurance Premium	Facility Costs			9,082,939			1,198	7
8	32	Interest Expense	Facility Costs			31,744,386			29,670	8
9	34	Rental & Leasing	Facility Costs			60,829,914			42,618	9
10	43	Other Expenses	Facility Costs			8,511,848			49,283	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 187,792,602	\$		\$ 198,331	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7	Home Office Allocation										29,670	7	
8												8	
9	TOTAL Facility Related						\$	\$			\$ 29,670	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$	\$			\$ 29,670	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

Facility Name & ID Number **ODIN HEALTHCARE CENTER**# **0039503**

Report Period Beginning:

01/01/00

Ending:

12/31/00**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	37,981	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	42,472	2
3. Under or (over) accrual (line 2 minus line 1).	\$	4,491	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	35,514	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For 19 _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	40,005	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995	35,172	8		
	1996	37,088	9		
	1997	37,431	10		
	1998	41,274	11		
	1999	42,472	12		

	FOR OFF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 1999	\$		13
14	PLUS APPEAL COST FROM LINE 5	\$		14
15	LESS REFUND FROM LINE 6	\$		15
16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

X. BUILDING AND GENERAL INFORMATION:

A.

Square Feet:

42,500

B. General Construction Type:

Exterior

BRICK

Frame

STEEL

Number of Stories

1

C.

Does the Operating Entity?

☒

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D.

Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E.

List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F.

Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	FACILITY	269,000	1994	\$ 80,743	1
2					2
3	TOTALS	269,000		\$ 80,743	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	99		1994	1975	\$ 3,360,767	\$ 96,022	35	\$ 96,022		\$ 630,814	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	SEE ATTACHED - See page 12.1			1994	782,958	39,148	20	39,148		256,096	9
10	REPAIR SIDEWALK			1996	819	41	20	41		175	10
11	ROOFTOP A/C - See page 12.2			1996	16,378	819	20	819		4,839	11
12	INSTALL AWNING			1997	2,845	142	20	142		547	12
13	WATER HEATER - See page 12.2			1997	1,388	69	20	69		321	13
14	WATER HEATER INSTALL - See page 12.2			1997	6,645	332	20	332		1,558	14
15	ELECTRICAL			1998	357	9	20	9		27	15
16	HVAC			1998	1,516	38	20	38		114	16
17	PLUMBING			1998	2,853	71	20	71		213	17
18	WATER HEATER			1998	3,885	97	20	97		291	18
19	RECONCILING ADJUSTMENT TO WTB 1998					86,553			(86,553)		19
20	A.O. SMITH 75 GAL GAS			1999	1,818	182	10	182		364	20
21	100G GAS WATER HEATER			2000	1,397	93	10	93		93	21
22	12: ZONELINE HVAC UNITS			2000	8,579	286	15	286		286	22
23	FIRST Q DIGITAL RESET			2000	1,224	82	10	82		82	23
24	W/G & MAGLOCKS SYSTEM			2000	3,817	127	10	127		127	24
25	2200 SQ FT FLATROOF DOWN PYMT			2000	9,899	247	10	247		247	25
26	ROOF SHINGLES, 18000 SQ FT			2000	11,072	277	10	277		277	26
27	WANDERGUARD SYSTEM			2000	3,615	241	10	241		241	27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$ 4,221,832	\$ 224,876		\$ 138,323	\$ (86,553)	\$ 896,712	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 230,629	\$ 23,191	\$ 23,191	\$		\$ 115,137	37
38	Current Year Purchases	12,651	529	529			529	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	\$ 243,280	\$ 23,720	\$ 23,720	\$		\$ 115,666	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				\$	\$	\$	\$		\$	42
43										43
44										44
45										45
46	TOTALS			\$	\$	\$	\$		\$	46

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 4,545,855	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 248,596	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 162,043	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ (86,553)	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 1,012,378	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	Overhead Allocation - Improvements	\$ 2,579	\$ 129	\$ 527	52
53	Overhead Allocation - Improvements	1,035	52	178	53
54	Overhead Allocation - Improvements	117	6	19	54
55					55
56					56
57	TOTALS	\$ 3,731	\$ 187	\$ 724	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 8,648 Description: Facility G/L - See page 14.1

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2001 \$ _____

13. /2002 \$ _____

14. /2003 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract	Total		
1	Community College Tuition	\$	\$	\$	\$		
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$	\$	\$	\$		
10	SUM OF line 9, col. 1 and 2 (e)	\$					

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		567 hrs	\$ 13,886		\$	\$ 119	567	\$ 14,005	1
2	Licensed Speech and Language Development Therapist		623 hrs	12,619				623	12,619	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		823 hrs	20,304			173	823	20,477	4
5	Physician Care		visits							5
6	Dental Care		visits			3,420			3,420	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts			10,503	76,009		86,512	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Audiologist					154			154	13
14	TOTAL			\$ 46,809		\$ 14,077	\$ 76,301	2,013	\$ 137,187	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 900	\$	1
2	Cash-Patient Deposits	10,077		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	422,317		3
4	Supply Inventory (priced at)	11,386		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 444,680	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	829,386		13
14	Buildings, at Historical Cost	1,457,224		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	89,334		16
17	Accumulated Depreciation (book methods)	(628,390)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,747,554	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,192,234	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 368,357	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	102,666		30
31	Accrued Taxes Payable (excluding real estate taxes)	13,895		31
32	Accrued Real Estate Taxes(Sch.IX-B)	35,514		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See page 17.1 Supplemental Schedule	213,668		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 734,100	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See page 17.1 Supplemental Schedule	6,198,334		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 6,198,334	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,932,434	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (4,740,200)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,192,234	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (5,331,492)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (5,331,492)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	591,292	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 591,292	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (4,740,200)	24 *

* This must agree with page 17, line 47.

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,109,679	1
2	Discounts and Allowances for all Levels	(945,059)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,164,620	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	545,854	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 545,854	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	10,928	13
14	Non-Patient Meals	(29)	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	157,248	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	33,934	19
20	Radiology and X-Ray		20
21	Other Medical Services	11,228	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 213,309	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Machine	1,081	28
28a	Miscellaneous Receipts	(501)	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 580	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,924,363	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	537,080	31
32	Health Care	1,055,155	32
33	General Administration	542,627	33
	B. Capital Expense		
34	Ownership	40,014	34
	C. Ancillary Expense		
35	Special Cost Centers	103,843	35
36	Provider Participation Fee	54,352	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,333,071	40
41	Income before Income Taxes (line 30 minus line 40)**	591,292	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 591,292	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **ODIN HEALTHCARE CENTER**# **0039503**Report Period Beginning: **01/01/00**Ending: **12/31/00**

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,060	2,213	\$ 44,988	\$ 20.33	1
2	Assistant Director of Nursing	1,410	1,515	25,777	17.01	2
3	Registered Nurses	13,452	14,454	227,428	15.73	3
4	Licensed Practical Nurses	8,398	9,024	119,739	13.27	4
5	Nurse Aides & Orderlies	38,463	41,333	335,476	8.12	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	2,024	2,175	51,078	23.48	7
8	Rehab/Therapy Aides	5,143	5,527	104,695	18.94	8
9	Activity Director	1,985	2,132	18,773	8.81	9
10	Activity Assistants	2,097	2,253	14,817	6.58	10
11	Social Service Workers	1,929	2,072	23,942	11.56	11
12	Dietician					12
13	Food Service Supervisor	1,706	1,833	20,666	11.27	13
14	Head Cook	5,964	6,408	54,059	8.44	14
15	Cook Helpers/Assistants	7,509	8,068	59,360	7.36	15
16	Dishwashers					16
17	Maintenance Workers	1,777	1,909	19,936	10.44	17
18	Housekeepers	11,500	12,356	84,142	6.81	18
19	Laundry	4,301	4,621	28,539	6.18	19
20	Administrator	1,977	2,124	48,422	22.80	20
21	Assistant Administrator					21
22	Other Administrative	2,051	2,204	24,705	11.21	22
23	Office Manager					23
24	Clerical	2,786	2,993	36,335	12.14	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	509	546	3,763	6.89	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Marketing Super</u>	654	702	11,538	16.44	33
34	TOTAL (lines 1 - 33)	117,695	126,462	\$ 1,358,178 *	\$ 10.74	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	183	\$ 7,002	1-3	35
36	Medical Director	192	5,812	9-3	36
37	Medical Records Consultant	31	1,950	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	39	1,529	11-3	44
45	Social Service Consultant	39	1,838	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	483	\$ 18,131		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount
Roxanne Summers	Administrator	0	\$ 57,365	Workers' Compensation Insurance	\$	31,531	IDPH License Fee	\$ 200
				Unemployment Compensation Insurance		18,577	Advertising: Employee Recruitment	
				FICA Taxes		99,815	Health Care Worker Background Check	
				Employee Health Insurance		80,797	(Indicate # of checks performed _____)	
				Employee Meals			Subscriptions	390
				Illinois Municipal Retirement Fund (IMRF)*		3,878	Dues	5,378
				Other Employee Benefits		3,030		
TOTAL (agree to Schedule V, line 17, col. 1)							Home Office Allocation	208
(List each licensed administrator separately.)								
							Less: Public Relations Expense	()
							Non-allowable advertising	()
							Yellow page advertising	()
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)	\$	237,628	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 6,176
Description			Amount					
			\$					
TOTAL (agree to Schedule V, line 17, col. 3)								
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Professional Services	Legal Fees		\$ 1,895			\$	Out-of-State Travel	\$ 775
							In-State Travel	6,972
							Home Office Allocation	1,881
							Seminar Expense	200
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$2500 attach copy of invoices.)							TOTAL	\$ 9,828
			\$ 1,895					

* Attach copy of IMRF notifications

**See instructions.

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)**

[illegible]

Facility Name & ID Number ODIN HEALTHCARE CENTER

STATE OF ILLINOIS

0039503

Report Period Beginning:

01/01/00

Ending:

Page 23

12/31/00

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. Illinois Healthcare Association
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 12 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ _____ Line _____
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 54,352
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? YES Indicate the amount. \$ 10,928
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? YES
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 0%
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.